

HEALTH CARE BENEFITS AT-A-GLANCE

Health Maintenance Organization (HMO) Managed by Kaiser Permanente

| | |
|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician Network Area | Metropolitan Washington D.C., including Northern Virginia and Baltimore areas; includes the City of Fredericksburg, Spotsylvania and Stafford Counties, and portions of Caroline, Culpeper, Fauquier, Hanover, King George, Orange and Westmoreland Counties. |
| Plan Contact Information | Kaiser Customer Service: (301) 468-6000 Website: www.kaiserpermanente.org |
| Primary Care Physician | Yes – required Referrals required |
| Annual Deductible | N/A |
| Yearly Out-of-Pocket Limit | \$3500 individual/\$9400 family |
| Office Visits (Physician or Specialist) | Covered in full after \$10 copay. All preventive care visits for physicals, pap smears, immunizations, etc. covered in full. No charge for children up to age 5. |
| Inpatient Hospital Care/Doctor's Services | Covered in full. |
| Laboratory & X-ray | Covered in full. |
| Prescription Drugs | <i>Kaiser pharmacy (up to 30 day supply):</i> \$10 copay for generic \$20 copay for brand formulary \$35 copay for brand non-formulary <i>Mail Order (up to 90 day supply):</i> \$16 copay generic \$36 copay brand formulary \$66 copay brand non-formulary |
| Maternity Care | Covered in full after \$10 copay on first pre-natal visit. |
| Well Child Care | Covered in full. |
| Preventive Care Visits | Covered in full. |
| Emergency Treatment | Covered in full after \$150 copay per visit. Waived if admitted. |
| Mental Health Services and Substance Abuse Treatment | Inpatient – Covered in full when medically necessary. Outpatient - \$10 individual visit copay; \$5 group visit copay. |
| Infertility Coverage | Coverage for in-vitro fertilization for up to 3 completed attempts per lifetime; covered at 50% of allowable charges. |
| Dental Care (additional coverage available through Delta Dental plan – separate premium required) | Discounts on services. |
| Hearing Aids | 1 hearing aid/ ear/ every 36 months, \$1,000 maximum. |
| Routine Vision Care | In addition to Davis Vision benefits, eye refraction exam/ ophthalmology visits: \$10 copay; eyewear/contact lens discounts also available. |